

CASE REPORTS

◀ Non-Tuberculous Psoas Abscess

◀ Infectious Mononucleosis

Non-Tuberculous Psoas Abscess

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PSOAS abscesses are of two kinds, tuberculous and non-tuberculous. Most textbooks give the impression that the tuberculous abscesses are far the more common but Bahn¹ in 1943 reported that of 35 cases of psoas abscess observed at the Charity Hospital in New Orleans, 60 per cent were tuberculous and 40 per cent were non-tuberculous.

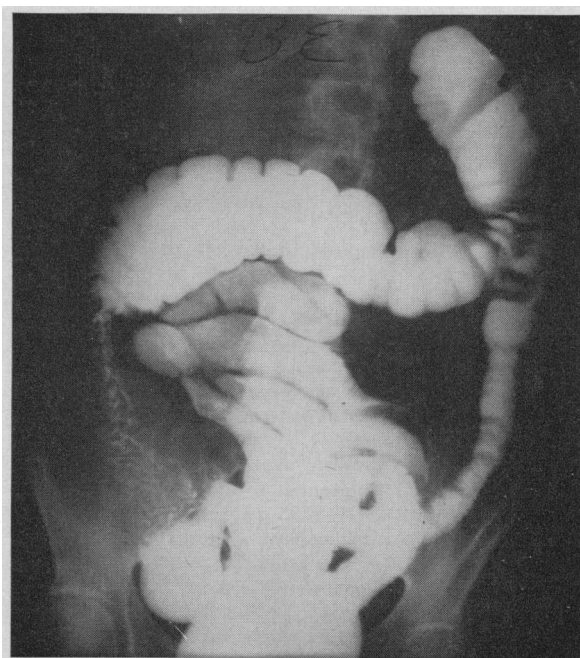
Because the diagnosis of non-tuberculous psoas abscess is so easily missed and because the condition receives very little attention in the current literature, the following case is reported.

REPORT OF A CASE

A 53-year-old white housewife complained of pain, of ten days' duration, in the right lower quadrant of the abdomen and the right leg. The onset of these symptoms followed a severe head cold. Three years earlier a similar attack had occurred. At that time the patient was hospitalized for a few days but no definite diagnosis was established. In the intervening years the patient had remained reasonably well although there were occasional attacks of pain in the right lower quadrant of the abdomen and down the leg. Treatment was not sought during these attacks. There were no associated symptoms referable to the gastrointestinal or the genito-urinary tract. On examination an ill-defined mass was palpated in the right lower quadrant of the abdomen. It extended from the flank to the groin and seemed to be retroperitoneal. The liver and the spleen could not be felt and the pelvic organs were normal to palpation. Motion of the right hip was free. There was slight pitting edema of the right leg without clinical evidence of thrombophlebitis. The heart and lungs were normal. Blood pressure was 110 mm. of mercury systolic and 80 mm. diastolic.

Results of urinalysis were within normal limits. In examination of the blood, moderate anemia was noted and leukocytes numbered 15,950. Result of a Wassermann test was negative for syphilis. No abnormality was observed in an x-ray film of the chest. In a film of the abdomen there was obliteration of the right psoas shadow. The lumbar spine was normal roentgenographically, both on anteroposterior and on lateral view. In barium studies the stomach and the upper intestinal tract were normal in appearance but a filling defect of the cecum and the ascending colon was observed. The impression was that of an extrinsic mass. In excretory urograms some downward displacement and rotation of the right kidney was noted. There was slight clouding of the costophrenic angle on the right.

The patient was febrile, with temperature elevations to 102° F. After one week of observation, operation was carried out. The provisional diagnosis was retroperitoneal abscess of undetermined origin. The incision extended from the tip of the last rib to the groin. There was a giant abscess in



Roentgenogram with barium enema. Note the poor filling of the ascending colon because of pressure from the psoas abscess.

the retroperitoneal region, overlying the psoas and extending from the second lumbar vertebra to the groin. The cavity was as large as a fist and contained about a pint of thick, creamy pus. No organisms were observed in a smear of the pus, and none grew on a culture. The ascending colon, the cecum, and the appendix were carefully palpated through the peritoneum. No lesions were noted. The right kidney was also normal to palpation. The abscess was drained through a stab wound in the groin and the main incision was closed. A biopsy specimen from the wall of the abscess was reported as non-specific inflammatory tissue.

Convalescence was uneventful. All drainage stopped within three weeks and the patient felt well.

DISCUSSION

Pyogenic psoas abscess may be hematogenous, lymphogenous, traumatic, or idiopathic. It may also originate by direct spread from adjacent organs.

Hematogenous abscesses are those following puerperal sepsis and pneumonia. Lymphogenous abscesses result from breakdown and suppuration of lymph nodes under the psoas fascia. Traumatic abscesses start in a hematoma. Direct extension occurs from neighboring structures, particularly the kidney and the appendix, but also the colon, the pelvic organs, and even the ischiorectal fat.

It is interesting to speculate upon the etiologic classification of the case here reported and upon how long the abscess had been present. As the urine was normal, as no abnormality was observed in a urogram, and as the kidney was normal to palpation, it is improbable that the abscess was of renal origin. The intestinal tract was normal and so was the lumbosacral spine. Therefore, the common foci were not present there. In all probability, the lesion was lymphogenous, beginning from lymphadenitis of the psoas region three years previously, the nodes then gradually breaking down and forming a sterile abscess which remained dormant during the intervening years. Eventually, perhaps under the stimulus of upper respiratory tract infection, the abscess spread rapidly along the established anatomical planes, causing the symptoms noted.

In the acute phase, most of the salient features of pyogenic psoas abscess were present:

1. There was pain and a mass in the right lower quadrant of the abdomen, together with evidence of sepsis.

2. Fixation of the hip in flexion—a sign that occurred in 58 per cent of the cases reported by Bahn—was not present. Edema of the leg, which was not present in any of Bahn's patients, was noted in the present case. This edema was undoubtedly due to pressure on the pelvic veins.

3. There was roentgenologic evidence of a tumor pressing on the ascending colon and there was partial obliteration of the psoas shadow. The curvature of the spine that has been described in reports of psoas abscess was not present.

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REFERENCE

1. Bahn, G. C.: Psoas abscess: Series of 35 cases and survey of the literature, *Journal Louisiana State University School of Med.*, 4:4, Nov.-Dec. 1943.

Infectious Mononucleosis

With Report of Four Cases

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INFECTIONOUS mononucleosis is of interest because it may simulate many other disease syndromes. Interest in the disease has also been stimulated by recent reports of fatalities^{8, 11, 18} from what had been described previously as an invariably benign illness. It therefore seems worthwhile to review some of the protean manifestations of this disease.

Correct diagnosis is essential in differentiating this usually benign condition from such malignant diseases as acute leukemia. It may also be important in explaining such vague symptoms as weakness and fatigue.²

The diagnosis of mononucleosis depends on a high degree of suspicion on the part of the examining physician. The manifestations are protean because the characteristic perivascular infiltration of abnormal lymphocytes may occur in various organs and systems in different cases.³

The disease may present itself as a generalized illness or it may involve a particular system. The most common manifestations are summarized in Table 1. Each may occur alone, although combinations of the various types of symptoms are more usual.¹⁷

Anginose mononucleosis may be confused with ordinary "sore throat," with hemolytic streptococcal sore throat, or with diphtheria. The following case from the records of the University of California Hospital is typical.

CASE REPORT

CASE 1: A 27-year-old woman had severe sore throat, fever, and membranous pharyngitis suspicious enough to justify administration of diphtheria antitoxin. A leukocyte differential count of 61 per cent lymphocytes, including 20 per cent atypical cells, and a heterophil antibody titer of 1:3584 established a diagnosis of mononucleosis.

Fever commonly accompanies some of the other manifestations, although it may occur as the chief symptom. Thus, mononucleosis is one of the causes of "fever of undetermined origin." In the following two cases taken from the records of University of California Hospital, diagnoses of

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typhoid fever and bacterial endocarditis, respectively, were seriously considered until the true diagnosis of mononucleosis was established.

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CASE 2: A 26-year-old male dental student was admitted to the hospital the first day of a febrile illness. Lymph nodes and spleen did not become enlarged.

Positive agglutination with "H" and "O" antigens at 1:320 dilution, in association with leukopenia (3,600 leukocytes per cu. mm.), led to strong suspicion of typhoid fever. The patient became afebrile in the second week of illness, the lymphocytes increased to 44 per cent of the number of leukocytes, with several atypical forms, and the heterophil titer rose from 1:28 initially to 1:112. The patient was discharged from the hospital with a diagnosis of mononucleosis.

CASE 3: A 43-year-old male, who had had rheumatic fever repeatedly in childhood and had been followed in the cardiac clinic for aortic and mitral valvulitis, reported to the clinic with complaint of chills and fever of one week's duration. Because of the presence of splenomegaly and a single splinter hemorrhage, a diagnosis of subacute bacterial endocarditis was entertained and immediate hospitalization was arranged. There was no pathogenic bacterial growth on five blood cultures. The heterophil antibody titer was 1:448.

TABLE 1.—Symptoms of Various Kinds of Infectious Mononucleosis

Type	Symptoms
Anginose	Sore throat
Febrile	Chills, fever, sweats, malaise
Glandular	Tender, painful nodes
Pulmonary	Cough, chest pain, x-ray findings as in atypical pneumonia
Abdominal	Pain, nausea, vomiting
Hepatic	Anorexia, nausea, vomiting, icterus
Central nervous system	Headache, stiff neck, paralysis
Eruptive	Rash resembling rubella, scarlet fever, etc.
Insidious	Fatigue, malaise
Hemorrhagic	Bleeding
Tumorous	Tumefaction